JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HUMAN SERVICES
OFFICE OF CHILDREN AND ADULT LICENSING

MARIANNE UDOW
DIRECTOR

RE: ADULT FOSTER CARE FAMILY HOME APPLICATION

Dear Applicant:

The following is information regarding application for an adult foster care family home for 6 or less. Your application for licensure will not be considered complete until you have demonstrated compliance with all applicable licensing requirements. Instructions and additional materials are included to assist you in completing the application.

Please return all of the completed and required application materials with a check or money order (which is non-refundable) payable to the "State of Michigan" in the amount of $65.00 to:

Michigan Department of Human Services
Cashier
P.O. Box 30759
Lansing MI 48909-8150

Please note that once you have submitted your application you may not add or delete a licensee name from the application or change the facility type you have indicated on your application. These changes require that you submit a new application and a new fee. **Fees are non-transferable**. When a new application is required, fees previously submitted cannot be credited to the new application.

It is therefore strongly recommended that you contact the local field office and speak with a licensing consultant prior to submitting your application and fee to assure that you are submitting the correct application, for the correct facility type, with the appropriate licensee name. You may find the local field office listing online at http://www.michigan.gov/dhs. Click on the "Doing Business with DHS" button on the left side, then go to "licensing" and select "contact information" in the "contact us" box.

For additional information, please contact the Licensing Unit at 866-685-0006 or Fax at (517) 335-6121.

Thank you.

Enclosure

Adult Foster Care Inquirer & Applicant Assistance

In an effort to better serve Adult Foster Care (AFC) inquirers and applicants, the Office of Children and Adult Licensing (OCAL) offers application assistance. There is an online tutorial on our website located at: http://www.michigan.gov/dhs/0,1607,7-124-5455_27716_27717---,00.html. Field office staff also provide this assistance; some may present this information in a group-meeting format.

The information provided on the website or by individual local office staff:

- Presents an overview of the licensing application process
- Is intended to assist you in making an informed decision about applying for an AFC license
- Is intended to assist you in identifying the type of license application to complete and the category of AFC facility you wish to apply.

You are encouraged to review the online tutorial and/or contact your assigned OCAL field office **before submitting an application**. Please review the attached OCAL office area coverage list, find the county where the proposed facility will be located, and contact the assigned OCAL field office indicated for application assistance.

The following OCAL field offices provide individual one on one information meetings; you must call the assigned office for an appointment: Ann Arbor, Bloomfield Hills, Escanaba, Flint, Grand Rapids, Jackson, Lansing, Marquette, Midland, Saginaw and Traverse City.

The following OCAL field offices provide group information meetings; you must call the assigned office for an appointment: Detroit and Kalamazoo.

The Mt. Clemens office provides phone conference information provided by licensing staff.

OCAL Office Area	Area by County/Zip Code	Telephone #	OCAL Office Area	Area by County/Zip Code	Telephone #
Ann Arbor		**734-665-4740**	**Lansing**		**517-335-6124**
48101-Allen Park	48122,48174-New Boston		Barry	Kent (Ada 49301, Alto 49302, Belding 48909, Caledonia 49316, Kentwood 49508, 49512, 49548, 49546, Lowell 49331	
48111-Belleville	48167, 48170-Northville		Clinton		
48111-Brownstown Twp	48170-Plymouth		Gratiot		
48183-Brownstown	48239,48240-Redford		Ingham	Mecosta	
48187,48188-Canton	48164,48192,48194-Riverview		Ionia	Montcalm	
48120,21,23-26,28 Dearborn	48174-Romulus			Shiawassee	
48127-Dearborn Heights	48173-Rockwood				
48229-Ecorse	48195-Southgate		**Marquette**		**906-228-0780**
48134-Flat Rock	48111-Sumpter Twp		Alger	Keweenaw	
48136-Garden City	48180-Taylor		Baraga	Luce	
48134-Gibraltar	48101,48183-Trenton		Chippewa	Mackinac	
48173-Grosse Ile	48111-VanBuren Twp		Delta	Marquette	
48138-Huron Twp	48184-Wayne		Dickinson	Menominee	
48141-Inkster	48185,48186-Westland		Gogebic	Ontonagon	
48146-Lincoln Park	48192-Wyandotte		Houghton	Schoolcraft	
48164-Melvindale			Iron		
Bloomfield Hills		**248-975-5051**	**Midland**		**989-839-1144**
Oakland	Livonia		Bay	Midland	
48150-48152,48154			Clare	Missaukee	
			Gladwin	Roscommon	
DETROIT		**313-456-0380**	Isabella	Saginaw (all zip codes not covered by Saginaw and Flint)	
City of Detroit	Harper Wood 48225				
Grosse Pointe 48136	Highland Pk 48203				
Hamtramck 48212	River Rouge 48218				
			Mt. Clemens		**248-975-5051**
Flint		**810-760-2598**	Huron	St. Clair	
Genesee			Lapeer	Sanilac	
Saginaw Co. (48415 Birch Run, 48417 Burt, 48457 Montrose, 48616 Chesaning, 48722 Bridgeport, 48734 Frankenmuth, 48757 Reese)			Macomb		
Tuscola					
			Saginaw		**989-758-1754**
			Alcona	Ogemaw	
Grand Rapids		**616-356-0100**	Alpena	Oscoda	
Kent -all zip codes not	Newaygo		Arenac	Saginaw 48601	
covered by Lansing	Oceana		Montmorency		
Lake	Osceola				
Manistee	Ottawa				
Mason					
Muskegon			**Traverse City**		**231-922-5300**
			Antrim	Grand Traverse	
Jackson		**517-780-7159**	Benzie	Kalkaska	
Branch	Lenawee		Charlevoix	Leelanau	
Eaton	Livingston		Cheboygan	Otsego	
Hillsdale	Monroe		Crawford	Presque Isle	
Jackson	Washtenaw		Emmet	Wexford	
Kalamazoo		**269-337-5066**			
Allegan	Kalamazoo				
Berrien	St. Joseph				
Calhoun	VanBuren				
Cass					

ORIGINAL APPLICATION INSTRUCTIONS
ADULT FOSTER CARE FAMILY HOMES
1-6 RESIDENTS

This instruction sheet specifies forms and information that must be completed and submitted before an on-site inspection can be conducted or a license can be issued.

The Family Home licensee(s) is required to be a member of the household and an occupant of the residence. A Family Home license cannot be issued to a corporation or limited liability company. Compliance with Public Act 218 of 1979 as amended, the Adult Foster Care Facility Licensing Act and the Administrative Rules for AFC Family Homes is your responsibility.

Please submit the following:

A. APPLICATION (OCAL-569-I)

Complete all areas; sign and date it.

B. LICENSE APPLICATION FEE

A check or money order in the amount of $65.00 payable to the "State of Michigan".

PLEASE DO NOT SEND CASH

C. LICENSING RECORD CLEARANCE REQUESTS (OCAL-1326A)

Public Act 218, of 1979, as amended, Sec 13 (3)(c)(e) requires that an applicant, all employees and all members of the household be of good moral character. The Department will determine compliance for the individuals listed below. In order for the Department to determine compliance, a Licensing Record Clearance Request will need to be completed and submitted for:

- **License Applicant(s)**, as listed on the application.
- **Members of the household, 18 years of age or older, who live in the home and are not foster care residents.** These individuals must be listed on the application.

Persons completing this form should **ONLY** complete Section II of the Clearance Request (OCAL-1326A). Return the **completed, signed and dated** forms with your application. If additional forms are needed, please contact the Licensing Unit. This information is mandatory. The licensing process will not proceed until this information has been received and the Clearance Request(s) processed by the Licensing Unit.

Additional Documentation You Will Need To Provide to the Consultant and Maintain in the Home:

_____ **R 400.1405 (2) Medical Clearance Request or equivalent.** You must provide a Medical Clearance Request (OCAL 3704), or its equivalent, completed by a

licensed physician or their designee for each license applicant and each responsible person. It cannot be dated more than 6 months prior to license issuance. It is recommended that you do not have the Medical Clearance Request completed until you speak to a consultant.

_____ **R 400.1405 (3) Tuberculosis.** You must provide written evidence that each license applicant and responsible person is free from communicable tuberculosis.

_____ **R 400.147 (10) House guidelines**. If you intend to have resident house guidelines, you will need to submit them to your consultant for review and approval.

_____ **R 400.1438 (1) Evacuation Plan.** You will need to develop an evacuation plan and written procedures to be followed in case of fire, medical and severe weather emergency. You will need to submit your evacuation plan to your consultant for review and approval.

_____ **Section 400.734 (a) Good Moral Character of Employee.** See enclosed.

NOTE: The items above are only some of the required documents and information. Your licensing consultant may ask for additional information as part of the licensure process. **It is your responsibility to review the rules and statutory requirements and demonstrate compliance to the department.** A recommendation for license issuance cannot be made and your application will not be considered complete, until all the items listed above, as well as any requested by your consultant, have been reviewed and approved by the department.

ENVIRONMENTAL HEALTH INSPECTIONS

If you have a well and/or private sewage disposal system, it will need to be inspected by the local county health authority. **The Department will arrange for this inspection.**

Enclosures: OCAL 569-I Application
OCAL 1326A AFC Licensing Clearance Request
OCAL 3704 Medical Clearance Request
Requirements of Sec. 34a/ Criminal Record Checks
Public Act 218 of 1979, as amended
Administrative Rules for Adult Foster Care Family Homes

Requirements of 400.734a/Criminal Record Checks

Effective 8/1/04, Act 59, which amends Public Act 218, requires that you not employ or independently contract with an individual who regularly provides direct services to residents if the individual has been convicted of one or more of the following:

(a) A felony or an attempt or conspiracy to commit a felony within the last 15 years.
(b) A misdemeanor involving abuse, neglect, assault, battery, or criminal sexual conduct or involving fraud or theft against a vulnerable adult within the last 10 years.

To determine this, you are responsible for obtaining criminal history information from the Michigan State Police Department (MSP) or the Internet Criminal History Access Tool (ICHAT), with the written permission of the employment or contract applicant. Further, you are responsible for obtaining a written statement from the employment or contract applicant that the person has resided in the state of Michigan for 3 or more years.

If you are applying or are currently licensed for a facility with a capacity of **more than 6 residents**, effective 8/1/04, any persons you have made a good faith offer of employment or independent contract with, who will provide direct services to residents, and have been a resident of Michigan less than 3 years, their fingerprints are required to be submitted to the Michigan State Police Department for FBI criminal record checks. It is extremely important when completing the fingerprint criminal record request that you clearly indicate on the form that it is for an adult foster care facility inorder for the FBI response to be provided to the correct agency.

If you are applying or are currently licensed for a facility with a capacity **of 6 residents or less,** persons you have made a good faith offer of employment or independent contract with who have been a resident of Michigan less than 3 years, you will need to make a request to the Michigan State Police Department or state agency responsible for maintaining statewide criminal history information, of all the states in which the individual lived during the preceding 5 years, to conduct a criminal history check on the individual.

You are also responsible for having the applicant and all current employees or persons you contract with that provide direct services to residents, sign a statement that they agree to notify you of any future arrest or conviction.

If the employment or contract applicant has had a criminal history background check completed within the last 24 months for a previous adult foster care facility, health care facility or agency, you may obtain that information from that previous employer by having the applicant sign a statement that consents to the release of that criminal record check directly from that employer. It is unacceptable to receive this information from the employee or contract applicant.

You will need to establish an employer account with the MSP to facilitate the processing of criminal record checks. If you need to have the employment or contract applicants begin working before results are received, a conditional employment form must be complete. A sample form is available on the DHS Website/Doing Business with DHS/ Licensing/Forms & Applications.

Note: **The above documents must be maintained at the facility and made available for department review.**

ADULT FOSTER CARE LICENSE INDIVIDUAL APPLICATION

Michigan Department of Human Services
Office of Children and Adult Licensing

FOR DHS USE ONLY:

License Number:

Paid Amount:

Cashier:

For OCAL Use ONLY: Consultant Load #

SECTION I – FACILITY INFORMATION

1. Facility Name	2. Application Type ☒ Original ☐ Renewal ☐ Amended			3. License Number
4. Facility Street Address	5. City/Village	6. Township	7. State	8. Zip Code
9. County / 10. Zoning Authority ☐ Township ☐ City/Village	11. Telephone Number ( )	12. Fax Number ( )	13. New Construction ☐ Yes ☐ No	
14. Proposed Capacity	15. I would prefer: ☐ Males ☐ Females ☐ Both	16. Ages	17. Currently Certified As A Specialized Program or Requesting Certification ☐ Yes ☐ No	
18. Program Type(s) ☐ Mentally Ill ☐ Developmentally Disabled ☐ Aged ☐ Alzheimer's ☐ Wheelchair Accessible ☐ Physically Handicapped ☐ Traumatic Brain Injured			19. Water System ☐ Public ☐ Private	20. Sewer System ☐ Public ☐ Private
21. Facility Type ☐ Family Home 1-6 ☐ Small Group 1-6 ☐ Small Group 7-12 ☐ Large Group 13-20 ☐ Congregate 21 or more – EXISTING ONLY				

SECTION II – APPLICANT LICENSEE INFORMATION

All original applicants must complete a Licensing Record Clearance Request form.

22. Applicant Name	23. Social Security or Federal Tax ID Number	24. Telephone Number ( )		
25. E-mail Address		26. Fax Number ( )		
27. Street Address	28. City	State	Zip Code	
29. Mailing Address, if different (i.e. P.O. Box)	City	State	Zip Code	
30. Joint Applicant Name (if applicable)	31. Social Security or Federal Tax ID Number	32. Telephone Number ( )		
33. E-mail Address		34. Fax Number ( )		
35. Street Address	36. City	State	Zip Code	
37. Mailing Address, if different (i.e. P.O. Box)	City	State	Zip Code	

SECTION III – RESPONSIBLE AGENCY INFORMATION (If Applicable) Attach Additional sheets, if necessary

38. Agency Name and Address	39. Name of Contact Person	40. Telephone Number

SECTION IV – ADMINISTRATOR or RESPONSIBLE PERSON INFORMATION

Administrators must complete a Licensing Record Clearance Request form.

41. Group Home/Congregate Applicants. Print Name of Person Responsible for Daily Operation of the Facility (Administrator)

42. FAMILY HOME APPLICANTS ONLY: Provide the name(s) of at least one responsible adult, other than the applicant or joint applicant, who can provide up to 72 hours of emergency coverage for you. Responsible persons must have proof of current T.B. test results and a physician's statement that they are both physically and mentally capable of caring for and being around residents.

Name (Last, First, Middle)	Street Address (city, state and zip)	Telephone Number

43. Describe any convictions of the applicant, joint applicant, administrator, and non-employee adult members of the household. Do not include minor traffic violations.

44. Has the applicant or joint applicant now, or ever, operated an adult foster care facility, children's foster care facility, children's day care facility, child caring institution, child placing agency, or adult or children's camp? If "yes" please complete Item 46. ☐ Yes ☐ No

45. Have you ever been denied a license to operate an adult foster care facility, children's foster care facility, children's day care facility, child caring institution, child placing agency, or adult or children's camp? If "yes" please complete Item 46. ☐ Yes ☐ No

46, If "YES" to either Item 44 or 45, complete the following information. Include all currently and previously licensed programs and denied license applications. Attach additional sheets, if necessary.

Name of licensing/certifying agency	Type of care	License Number	Application Date	Open	Closed

47. Provide the following information for all persons who live in the facility, including relatives, roomers and boarders and live-in staff and children. Do not include adult foster care residents. All non-employee adult household members who are not residents must complete a Licensing Record Clearance Request form.

Name (Last, First, Middle)	Position or Relationship	Date of Birth

48. Directions for reaching family from Office of Children and Adult Licensing field office.

SECTION V – OWNERSHIP INFORMATION

49. Identify all ownership interest in the business. Include additional sheets if necessary.

NAME	ADDRESS (City, State and Zip Code)

50. Ownership of facility to be licensed: ☐ Own ☐ Rent/Lease ☐ Buying

51. Identify all ownership interest in the property. Include additional sheets, if necessary.

NAME	ADDRESS (City, State and Zip Code)

SECTION VI – FINANCIAL INFORMATION

All questions must be answered by the Applicant and Joint Applicant to the best of his/her knowledge. Attach an explanation for each question answered "Yes."

52. HAS THE APPLICANT OR JOINT APPLICANT EVER:

a.	Filed for Bankruptcy?	☐ Yes	☐ No	f.	Had a default judgement against it?	☐ Yes	☐ No
b.	Had a seizure of assets?	☐ Yes	☐ No	g.	Had a repossession or foreclosure?	☐ Yes	☐ No
c.	Had a lien enforced against it?	☐ Yes	☐ No	h.	Had a notice of eviction due to payment problems?	☐ Yes	☐ No
d.	Had financial assets frozen?	☐ Yes	☐ No	i.	Had a garnishment or attachment of wages or income?	☐ Yes	☐ No
e.	Had a contract to receive public or private monies not renewed or terminated prior to its expiration?					☐ Yes	☐ No

53. FOR FAMILY HOME APPLICANTS ONLY:

A. ☐ **I have sufficient resources to meet Rule 400.1404(4).** The department defines "sufficient resources as follows:

Original applicants have financial assets available to provide for the operation of the home for a period of at least three months. Renewal applicants have financial assets available to provide for the operation of the home for a period of at least 30 days.

These resources are from: (check all that apply)

- ☐ Applicant/Joint Applicants employment outside of adult foster care
- ☐ Non-Applicant/Joint Non-Applicant spouse's income
- ☐ Savings or available cash
- ☐ Funding contracts/Intent to contract statement
- ☐ Adult foster care income
- ☐ Other, specify

Please attach an explanation of all items checked. You may be required to provide verification and/or documentation of the financial information provided.

B. ☐ I do not have sufficient resources at this time to meet Rule 400.1404(4). *You may submit additional information for consideration*.

Section VII – CERTIFICATION AND SIGNATURES

I have read PA 218 of 1979, as amended, and the Administrative Rules regulating the operation of Adult Foster Care facilities. If granted a license I will comply with the Act and these Rules.

In order to permit a proper determination of conformity with the rules, I give permission to the Department of Human Services to make all necessary and reasonable investigations of my activities, proposed standards of care, and to make an on-site inspection of the proposed facility.

I am aware of the legal provisions of Section 13 and Section 31 of PA 218 of 1979, respectively, that operating an adult foster care facility without a license or to violate this Act is subject to criminal penalties, punishable by imprisonment or a substantial fine or both.

I certify that I will assess the good moral character of the employees of this home/facility, as required by PA 218. I certify that if I or any employee, volunteer, or household member of the facility who is on parole or probation or convicted of a felony will be reported to the Department.

I also certify that any information I give in respect to any investigation by the department will be, to the best of my ability, true and correct.

54. Applicant Name (print or type)	55. Applicant Signature	56. Date
57. Joint Applicant Name (print or type)	58. Joint Applicant Signature	59. Date

A LICENSEE FEE (which is non-refundable and non-transferable), payable by check or money order **ONLY**, to the **STATE OF MICHIGAN**, is to be sent in accordance with the Application Instructions. The fees are:

	ORIGINAL	RENEWAL		ORIGINAL	RENEWAL
Family Home 1 – 6	$ 65.00	$25.00	Large Group Home 13 – 20	$170.00	$100.00
Small Group Home 1 – 6	$105.00	$25.00	Congregate Facility 21+	$220.00	$150.00
Small Group Home 7 – 12	$135.00	$60.00			

The Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an DHS office in your area.

AUTHORITY:	Public Act 218 of 1979, as amended
COMPLETION:	Mandatory
NON-COMPLETION:	License issuance will be denied

AFC LICENSING RECORD CLEARANCE REQUEST

There are two purposes to this form:

1. Produce a Department of State Police check regarding the possible existence of a conviction record.
2. Produce a Central Files check against current or previous licensee status of the applicant in any county of the state.

The existence of a conviction record or a substantiated child abuse or neglect record does not necessarily disqualify an applicant for licensure. However, it does provide the Agency with information, which will be carefully evaluated by licensing staff.

A failure on the part of an applicant to provide OCAL with the information and authorization requested on this form may be sufficient cause to deny issuance of a license.

AUTHORITY:	Public Act 116 of 1973 as amended and Public Act 218 of 1979 as amended	Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.
COMPLETION	Required	
CONSEQUENCE:	Licensure may be denied.	

AFC LICENSING RECORD CLEARANCE REQUEST
STATE OF MICHIGAN
Department of Human Services
Office of Children and Adult Licensing

DIRECTIONS FOR COMPLETING FORM:
- **Please read the reverse side before completing this form.**
- **Please type or print CLEARLY so that the information completed can be read.**
- **Mail completed form to OCAL Central office.**

SECTION I: REQUESTOR INFORMATION (Must be completed by licensing consultant/worker)

Licensing Consultant/Worker Name, Address and Phone Number

Department of Human Services
Office of Children and Adult Licensing
7109 W. Saginaw St., 2nd Floor
P.O. Box 30650
Lansing, MI 48909-8150

Licensee/Applicant Name	County	License Number (If assigned)

License/Application Type: Adult Foster Care

SECTION II: CLEARANCE INFORMATION (To be completed by applicant or other person to be cleared – If more than one person is named on the application, each is to complete a OCAL-1326A)

The Person Being Cleared Is:

☐ Adult Member of Household (specify relationship to licensee):

☐ Applicant/Co Applicant ☐ Licensee/Licensee Designee ☐ Administrator (Responsible Person in charge of daily operations)

Name (Last, First, Middle Jr., II, etc.)	Sex	Birth Date	Social Security Number

Marital Status	Also Known As (Aliases, Maiden Name, Previous Married Name(s))	Michigan Drivers License Number
☐ SGL ☐ MAR ☐ DIV		

Address (Street Number and Name)	How Long Have You Lived In This State? County?	Race

City	County	State	Zip Code	Phone Number	Height	Weight

- I am aware that Michigan Department of State Police records will be checked for information regarding criminal convictions under authority of the Good Moral Character Statute.
- I am aware that the Department of Human Services Central Registry will be checked for information concerning substantiated child abuse and neglect.
- I certify that the information I have given on the form is, to the best of my ability, true and correct.
- The Department may perform this check at any time while I am licensed.

Have You Ever Been Convicted Of A Crime, Felony Or Misdemeanor?

☐ NO ☐ YES (If yes, explain)

Type, Location, and Date of Conviction(s)

Signature Of Person To Be Cleared	Date

SECTION III: CENTRAL RECORDS CLEARANCE (OCAL Use Only)

Previous License? ☐ NO ☐ YES	Initials	Clearance Date

License Number

SECTION IV: CONVICTION CLEARANCE

AFC LICENSING RECORD CLEARANCE REQUEST
STATE OF MICHIGAN
Department of Human Services
Office of Children and Adult Licensing

DIRECTIONS FOR COMPLETING FORM:
- **Please read the reverse side before completing this form.**
- **Please type or print CLEARLY so that the information completed can be read.**
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Department of Human Services
Office of Children and Adult Licensing
7109 W. Saginaw St., 2nd Floor
P.O. Box 30650
Lansing, MI 48909-8150

Licensee/Applicant Name	County	License Number (If assigned)

License/Application Type: Adult Foster Care

SECTION II: CLEARANCE INFORMATION (To be completed by applicant or other person to be cleared – If more than one person is named on the application, each is to complete a OCAL-1326A)

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☐ Adult Member of Household (specify relationship to licensee):

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Name (Last, First, Middle Jr., II, etc.)	Sex	Birth Date	Social Security Number

Marital Status	Also Known As (Aliases, Maiden Name, Previous Married Name(s))	Michigan Drivers License Number
☐ SGL ☐ MAR ☐ DIV		

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City	County	State	Zip Code	Phone Number	Height	Weight

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- I am aware that the Department of Human Services Central Registry will be checked for information concerning substantiated child abuse and neglect.
- I certify that the information I have given on the form is, to the best of my ability, true and correct.
- The Department may perform this check at any time while I am licensed.

Have You Ever Been Convicted Of A Crime, Felony Or Misdemeanor?

☐ NO ☐ YES (If yes, explain)

Type, Location, and Date of Conviction(s)

Signature Of Person To Be Cleared	Date

SECTION III: CENTRAL RECORDS CLEARANCE (OCAL Use Only)

Previous License? ☐ NO ☐ YES	Initials	Clearance Date

License Number

SECTION IV: CONVICTION CLEARANCE

MEDICAL CLEARANCE REQUEST

Michigan Department of Human Services
Office of Children and Adult Licensing
Division of Adult Foster Care & Home for the Aged Licensing

APPLICANT/LICENSEE INFORMATION

Facility/Home Name		License Number	
Facility/Home Address (Street Number and Name)	City	State	Zip Code

PLEASE MAIL TO ➡

Licensing Consultant (Name, Address, Phone)

Department of Human Services
Office of Children and Adult Licensing
7109 W. Saginaw St., 2nd Floor
P.O. Box 30650
Lansing, MI 48909-8150

License Application Type

- ☒ Adult Foster Care (24-Hour Care)
- ☐ Child Foster Care (24-Hour Care)
- ☐ Child Care (Less Than 24-Hour Care)
- ☐ Capacity _____

PATIENT INFORMATION (To be Completed by Patient) (Please Print or Type)

Name (Last, First, Middle, Jr., II, etc.)	Date of Birth	Social Security Number	Telephone Number
Address (Street Number and Name)	City	State	Zip Code

RELEASE OF INFORMATION (To be Completed by Patient)

I authorize the release of medical information concerning me to the care facility listed above and to the Michigan Department of Human Services, Office of Children and Adult Licensing, for the purpose of determining my suitability to provide or be associated with the care of children/dependent adults.

Date

Patient's Signature

Physician's Name (Please PRINT or TYPE)

MEDICAL INFORMATION (To be Completed by Physician)

- **This individual is, or will be, employed in a child/dependent adult care setting.**
- **It is necessary to establish that those providing care are in such physical and mental condition and health as not to adversely affect the health or safety of a child/dependent adult and the quality and manner of his/her care.**
- **To assist us in this determination, you are being asked to answer the following.**

Has this Person Been Tested for T.B.?	Date Tested	Test Type	Results
☐ No ☐ Yes If Yes ➡		☐ Skin Test ☐ X-Ray	☐ Positive (Explain in Comments) ☐ Negative

How would you describe the patient's general physical/mental condition and health? (Use Comments section for explanations)

- ☐ No physical/mental condition or health problem exists that would limit the ability to work with or around children/dependent adults.
- ☐ Physical/mental condition or health problem exists that would not limit the ability to work with or around children/dependent adults. Explain in Comments if reasonable accommodation may be needed.
- ☐ Physical/mental condition or health problem exists which would affect the ability to work with or around children/dependent adults, with or without reasonable accommodation.

Comments (Please use back of this form if additional space is needed.)

Would you like to be contacted by the licensing consultant regarding your recommendation? ☐ Yes ☐ No

Licensed Physician or his/her designee Signature	Signature Date	Telephone Number	Examination Date
Address (Street Number and Name)	City	State	Zip Code

AUTHORITY: Public Act 116 of 1973 as amended
Public Act 218 of 1979 as amended
RESPONSE: Voluntary
PENALTY: Application for licensure may be denied.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

MEDICAL CLEARANCE REQUEST

Michigan Department of Human Services
Office of Children and Adult Licensing
Division of Adult Foster Care & Home for the Aged Licensing

APPLICANT/LICENSEE INFORMATION

Facility/Home Name		License Number	
Facility/Home Address (Street Number and Name)	City	State	Zip Code

PLEASE MAIL TO ➡

Licensing Consultant (Name, Address, Phone)

Department of Human Services
Office of Children and Adult Licensing
7109 W. Saginaw St., 2nd Floor
P.O. Box 30650
Lansing, MI 48909-8150

License Application Type

- ☒ Adult Foster Care (24-Hour Care)
- ☐ Child Foster Care (24-Hour Care)
- ☐ Child Care (Less Than 24-Hour Care)
- ☐ Capacity _____

PATIENT INFORMATION (To be Completed by Patient) (Please Print or Type)

Name (Last, First, Middle, Jr., II, etc.)	Date of Birth	Social Security Number	Telephone Number
Address (Street Number and Name)	City	State	Zip Code

RELEASE OF INFORMATION (To be Completed by Patient)

I authorize the release of medical information concerning me to the care facility listed above and to the Michigan Department of Human Services, Office of Children and Adult Licensing, for the purpose of determining my suitability to provide or be associated with the care of children/dependent adults.

Date

Patient's Signature

Physician's Name (Please PRINT or TYPE)

MEDICAL INFORMATION (To be Completed by Physician)

- **This individual is, or will be, employed in a child/dependent adult care setting.**
- **It is necessary to establish that those providing care are in such physical and mental condition and health as not to adversely affect the health or safety of a child/dependent adult and the quality and manner of his/her care.**
- **To assist us in this determination, you are being asked to answer the following.**

Has this Person Been Tested for T.B.?	Date Tested	Test Type	Results
☐ No ☐ Yes If Yes ➡		☐ Skin Test ☐ X-Ray	☐ Positive (Explain in Comments) ☐ Negative

How would you describe the patient's general physical/mental condition and health? (Use Comments section for explanations)

- ☐ No physical/mental condition or health problem exists that would limit the ability to work with or around children/dependent adults.
- ☐ Physical/mental condition or health problem exists that would not limit the ability to work with or around children/dependent adults. Explain in Comments if reasonable accommodation may be needed.
- ☐ Physical/mental condition or health problem exists which would affect the ability to work with or around children/dependent adults, with or without reasonable accommodation.

Comments (Please use back of this form if additional space is needed.)

Would you like to be contacted by the licensing consultant regarding your recommendation? ☐ Yes ☐ No

Licensed Physician or his/her designee Signature	Signature Date	Telephone Number	Examination Date
Address (Street Number and Name)	City	State	Zip Code

AUTHORITY: Public Act 116 of 1973 as amended
Public Act 218 of 1979 as amended
RESPONSE: Voluntary
PENALTY: Application for licensure may be denied.

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